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No. 86-1986

In the Supreme Court of the United States

OCTOBER TERM, 1987

NORTH BROWARD HOSPITAL DISTRICT, PETITIONER

v.

OTIS R. BOWEN, SECRETARY
OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE RESPONDENT

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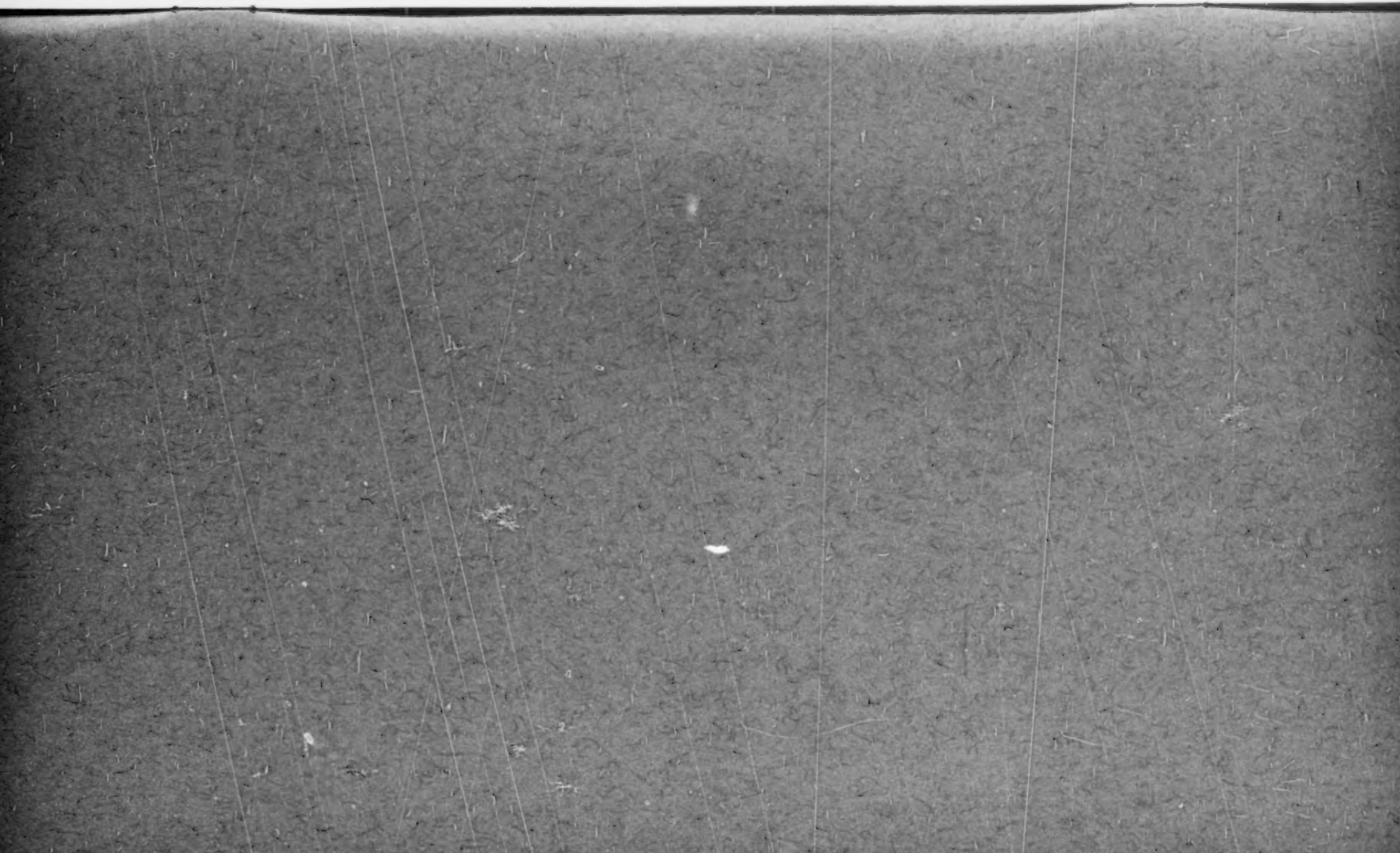

QUESTION PRESENTED

Whether the Provider Reimbursement Review Board may consider a health care provider's claim that it is entitled to reimbursement under the Medicare statute for a particular cost when the provider failed to seek reimbursement for that cost from its fiscal intermediary and did not otherwise reserve before the intermediary its right to seek reimbursement for that cost.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A3-A10) is reported at 808 F.2d 1405. The order of the district court (Pet. App. A11-A12) is unreported. The opinion of the Deputy Administrator, Health Care Financing Administration (Pet. App. A17-A20), is unreported. The opinions of the Provider Reimbursement Review Board (Pet. App. A21-A35) are unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. A37) was entered on January 12, 1987, and a petition for rehearing was denied on February 25, 1987 (Pet. App. A36). The petition for a writ of certiorari was filed on May 26, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. At the time of the events at issue in this case, all "providers" of health care services to Medicare beneficiaries were reimbursed by the Secretary of Health and Human Services on an annual basis for the "reasonable cost" of those health care services. 42 U.S.C. (& Supp. III) 1395f(b), 1395x(u) and (v)(1)(A).[1] Over the course of the year, the Secretary made payments to a provider based upon an estimate of the amounts owed to the provider. 42 U.S.C. 1395g; 42 C.F.R. 413.60. At the end of the year, the provider submitted a claim for reimbursement in the form of a "cost report." See 42 U.S.C. (& Supp. III) 1395f(a); 42 C.F.R. 413.20(a) and (b), 413.24(f).[2] The cost report is "a lengthy document consisting of numerous schedules, worksheets, and supplemental worksheets. * * * [A] cost report, when completed, is approximately three-quarters of an inch thick" (*Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984)). Providers list on the worksheets cost items for which they do not seek reimbursement because those cost items supply background information that supports the provider's cost claims.

The cost report is submitted to the provider's "fiscal intermediary" for review.[3] The intermediary audits the cost

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[1] These cases concern payments under "Part A" of the Medicare statute, which provides coverage for "the costs of hospital, related post-hospital, home health services, and hospice care" (42 U.S.C. 1395c).

[2] The report is due three months after the end of the provider's fiscal year. The provider may obtain a 30-day extension of the due date for "good cause." 42 C.F.R. 413.24(f)(2).

[3] The intermediary, which is generally a private insurance company, is an entity that, pursuant to a contract with the Secretary, acts as the Secretary's agent in reviewing the provider's claims and determining the amount of reimbursement owed to the provider. See 42 U.S.C. (& Supp. III) 1395h; 42 C.F.R. 421.3, 421.100-421.128.

report and issues a Notice of Program Reimbursement specifying the total amount of reimbursement due to the provider and explaining any adjustments to the costs claimed by the provider. See 42 C.F.R. 405.1803.[4]

If a provider has timely filed its cost report and is "dissatisfied with [the intermediary's] final determination * * * as to the amount of total program reimbursement due the provider" or has not received a final determination on a "timely basis," the provider "may obtain a hearing with respect to such cost report" before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. (& Supp. III) 1395*oo*(a)(1); see also 42 C.F.R. 405.1835.[5] The PRRB is authorized by statute (42 U.S.C. 1395*oo*(d)) to

> affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Board's decision is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. The Board's decision—or the Secretary's modified decision, if any—is subject to judicial review in federal district court pursuant to the Administrative Procedure Act. 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); 42 C.F.R. 405.1875-405.1877.

The statute establishes a second, more expeditious route into court in certain circumstances. A provider may obtain

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[4] The reimbursement award specified in the Notice of Program Reimbursement is compared to the Secretary's payments to the provider. Any deficiency is paid by the Secretary and any overpayment is repaid by the provider. 42 C.F.R. 405.1803(c), 413.60.

[5] Review by the PRRB is available only if the amount in controversy is $10,000 or more and the provider's request for a hearing is timely filed (42 U.S.C. (& Supp. III) 1395*oo*(a)(2) and (3)).

direct judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." 42 U.S.C. 1395*oo*(f)(1); see also 42 C.F.R. 405.1842.[6]

2. Petitioner, a special tax district created by the State of Florida, operates three public hospitals that are certified as providers of health services under the Medicare program. Petitioner's 1977 cost report listed certain charges imposed by the Broward County tax assessor and the Broward County tax collector in connection with the collection of the revenue needed to operate these hospitals, but petitioner did not seek reimbursement for these costs, *i.e.*, petitioner "self-disallowed" the costs. As the court of appeals observed, because petitioner's cost report "did not request reimbursement for its tax payments, the fiscal intermediary did not include the tax collection costs in its [Notice of Program Reimbursement], and there were no payments made to [petitioner] for the tax collection expenses." Pet. App. A5.

Petitioner appealed the intermediary's determination to the Provider Reimbursement Review Board and, while the appeal was pending, petitioner for the first time claimed that it was entitled to reimbursement for the tax collection expenses. The Board found that it had no jurisdiction over petitioner's claim (Pet. App. A21-A25, A26-A30, A31-A35).[7] It observed that "the costs for the tax assessment and tax collection issues were not claimed in the Provider's cost report(s); nor have any amended cost report(s) been accepted by the Intermediary on these issues; nor

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[6] A final decision may be reopened by the intermediary, the Board, or the Secretary in certain circumstances. See 42 C.F.R. 405.1885.

[7] The Board had initially indicated that it had jurisdiction over the claim (Pet. App. A21, A26, A31).

have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue" (*id.* at A21, A26, A31).

The Board stated that "[t]he statute and regulations require as a prerequisite for an appeal that the provider must be dissatisfied with its intermediary's final determination. The provider must have made an overt disclosure of its posture on a particular issue which is ordinarily evidenced by claiming reimbursement for the particular item in the cost report which the intermediary may then adjust in whole or in part" (Pet. App. A21-A22, A26-A27, A31-A32).[8] Because there was no determination of petitioner's cost claim by the intermediary, "no * * * claim made [by petitioner] in the filed cost reports, or overt notice given at the time they were filed of any disagreement with a reimbursement policy, etc.," there was "no controversy [over which] the Board [could] exercise its jurisdiction" (*id.* at A22, A27, A32). The Secretary's designee—the Deputy Administrator of the Health Care Financing Administration—affirmed the Board's determination (Pet. App. A17-A20).

Petitioner sought judicial review of the administrative determination, and the district court reversed (Pet. App. A11-A12). It stated that "[w]here a provider self-disallows costs in the cost report in a good faith effort to comply with medicare rules, the PRRB may assume jurisdiction to hear the issues raised thereby" (*id.* at A11).

3. The court of appeals, in turn, reversed the district court, and upheld the Board's determination that it lacked jurisdiction over petitioner's claims (Pet. App. A3-A10). As a threshold matter the court observed that the

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[8] The Board noted that "[s]elf-disallowed cost situations present a special problem because unless there is some clear overt disclosure (notice) of [the provider's] disagreement on a particular item, there is no method for creating a controversy as required by the statute [and] regulations" (Pet. App. A22, A27, A32).

Secretary's interpretation of the statute is entitled to "substantial deference" (*id.* at A6). It concluded that the Secretary's interpretation of the scope of the Board's jurisdiction is correct.

The court of appeals stated that "[t]he language of the statute is ambiguous as to whether the PRRB can consider reimbursement claims not disclosed in the cost report" (Pet. App. A8).[9] Relying upon the D.C. Circuit's decision in *Athens Community Hospital* v. *Schweiker*, 686 F.2d 989 (D.C. Cir. 1982) (*Athens I*), modified, 743 F.2d 1 (D.C. Cir. 1984) (Bork, J.) (*Athens II*), the court concluded that "[t]he only plausible construction of section 1395*oo*(d) requires that an expense be overtly disclosed and contested before the fiscal intermediary in order to be 'a matter covered by such report' and appealable before the PRRB; the Board may consider 'revisions' of the reimbursement of costs * * * [only to the extent that] such revisions '[are] necessary to accommodate other PRRB revisions of matters that were [expressly] claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB.' " Pet. App. A9 (quoting *Athens II*, 743 F.2d at 9).

The court stated that a contrary conclusion would "result in the elimination of the administrative review process clearly provided for in the Medicare statute and regulations" (Pet. App. A9). "A broader reading of PRRB jurisdiction, allowing any claim to be raised for the first time on appeal to the Board, 'would effectively nullify the

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[9] The court pointed out that while "the PRRB has the power only to review 'matters covered by such cost report,' " the statute "also provides that the [PRRB] shall base its decision upon 'the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board . . . even though such matters were not considered by the intermediary in making such final determination.' " Pet. App. A7-A8 (citations omitted).

language in the statute that limits the PRRB's authority to affirm, reverse or modify reimbursements to "matters covered by a cost report" ' and wreak havoc with the multi-tiered administrative appeals scheme" (*ibid.* (quoting *Athens II*, 743 F.2d at 6)). The court held that "a provider, to retain the right to appeal the decision on whether a cost is reimbursable, must either expressly request reimbursement for a cost item in its initial cost report or specifically contest the non-allowability of the item with its intermediary in or with the cost report" (Pet. App. A9).[10]

ARGUMENT

The question presented in this case is the same as the question presented in *Bethesda Hospital Ass'n* v. *Bowen*, petition for cert. pending, No. 86-1764, *i.e.*, whether the Provider Reimbursement Review Board may consider a claim for reimbursement that was not raised before the fiscal intermediary.[11] Here, the court of appeals concluded that the Board's jurisdiction "is limited to matters put into dispute by the provider at the time the cost report is filed" (Pet. App. A9), the same rule adopted by the court of appeals in *Bethesda Hospital Ass'n*. As we discussed in our response to the certiorari petition

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[10] The court observed that alternative means exist by which providers can preserve a claim for reimbursement, such as by seeking to reopen a previously filed cost report or self-disallowing costs while "append[ing] a letter to the cost report stating that such voluntary self-disallowance was performed only to comply with regulations which the provider wished to challenge" (Pet. App. A9-A10 n.7).

Judge Anderson concurred in the judgment, concluding that "deference to the agency's construction is due" because it "is not so strained as to be unreasonable, arbitrary or capricious" (Pet. App. A10).

[11] We have served petitioner's counsel with a copy of our response to the petition in *Bethesda Hospital Ass'n*.

(at 7-11), in *Bethesda Hospital Ass'n*, that conclusion regarding the scope of the Board's jurisdiction is supported by the language and structure of the Medicare statute, and by significant practical considerations. For the reasons stated in that response, however, we have suggested that the Court should grant the petition for a writ of certiorari in *Bethesda Hospital Ass'n*.

CONCLUSION

The petition for a writ of certiorari should be held and disposed of as appropriate in light of the disposition of *Bethesda Hospital Ass'n* v. *Bowen*, petition for cert. pending, No. 86-1764.

Respectfully submitted.

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* The Solicitor General is disqualified in this case.

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